VERMONT
HEALTH CARE REFORM

FIVE - YEAR IMPLEMENTATION PLAN

Submitted to:

GOVERNOR JAMES H. DOUGLAS
LEGISLATIVE COMMISSION ON HEALTH CARE REFORM
HEALTH ACCESS OVERSIGHT COMMITTEE
HOUSE COMMITTEE ON HEALTH CARE
SENATE COMMITTEE ON HEALTH AND WELFARE
SENATE COMMITTEE ON FINANCE

DECEMBER 1, 2006

SUSAN BESIO, PH.D
DIRECTOR, HEALTH CARE REFORM IMPLEMENTATION
STATE OF VERMONT AGENCY OF ADMINISTRATION

TABLE OF CONTENTS

HEALTH CARE REFORM BACKGROUND

INTRODUCTION

On May 25, 2006, Vermont Governor James Douglas signed into law Acts 190 and 191 (Acts Relating to Health Care Affordability for Vermonters). These Acts provide the foundation for Vermont's Health Care Reform Plan, augmented by portions of Act 215 (the Fiscal Year 2007 State Appropriations Act), Act 142 (Establishing a SorryWorks! Program), and Act 153 (Safe Staffing and Quality Patient Care).

Together, this comprehensive package of health care reform legislation is based on the following principles.[1]

(1) It is the policy of the state of Vermont to ensure universal access to and coverage for essential health care services for all Vermonters.
(2) Health care coverage needs to be comprehensive and continuous.
(3) Vermont's health delivery system must model continuous improvement of health care quality and safety.
(4) The financing of health care in Vermont must be sufficient, equitable, fair, and sustainable.
(5) Built-in accountability for quality, cost, access, and participation must be the hallmark of Vermont's health care system.
(6) Vermonters must be engaged, to the best of their ability, to pursue healthy lifestyles, to focus on preventive care and wellness efforts, and to make informed use of all health care services throughout their lives.

Using these principles as a framework, Vermont's health care reform is designed to simultaneously achieve the following three goals:

- ***Increase access to affordable health insurance for all Vermonters***
- ***Improve quality of care across the lifespan***
- ***Contain health care costs***

It is significant that Vermont's 2006 Health Care Reform Plan is the product of extensive negotiation and collaboration by the Douglas Administration, legislative leaders of the Vermont General Assembly, and the private sector participants in Vermont's health care system. While there were multiple ideas and political agendas as part of the discussions, there is agreement that the final legislation is comprehensive in its breadth and significant in its potential impact on health care in Vermont. There also is a commitment to move forward with implementation in a collaborative, non-partisan manner to maximize its success.

[1] *Act 191, Section 1.*

BACKGROUND – HEALTH CARE IN VERMONT

Affordable, comprehensive and high quality health care is essential for the well-being of Vermont's citizens, its communities, its employers, and the state as a whole. It also is critical that the efficiency of the healthcare system be addressed so scarce resources can be used in the best manner to sustain, improve or expand health services.

Per capita health care costs are lower in Vermont when compared to the U.S., but the spending gap has been narrowing since 1999. Health care spending growth rates in Vermont have exceeded national averages for each of the last six years, and health care costs are 14.7% of Vermont's gross state product. [2]

At the same time, access to affordable coverage and quality care continues to be a concern for our citizens. In 2003, the average family premium for health care coverage was $9,483. In addition, chronic conditions are the leading cause of illness, disability and death, and consume more than three quarters of the $3.3 billion Vermont spends on health care annually. However, national data indicate that only 55% of individuals with chronic illnesses receive the right care at the right time. In 2002, 84 percent of Vermonters said that a high priority for government should be to ensure that people get the health care they need. [3]

Vermont has had significant experience using its Medicaid waiver authority to expand coverage for the uninsured. The Dr. Dynasaur program provides Medicaid coverage to all children with household income under 300% FPL, to pregnant women with household income under 200% FPL, and to parents and caretakers with household income under 185% FPL. The Vermont Health Access Plan (VHAP) provides coverage for uninsured adults with household income under 150% FPL and adults with children on Dr. Dynasaur with income under 185%, with no asset test. As a result, Vermont has an uninsured rate of 9.8% (61,056) compared with a national rate of 15.7%, and an uninsured rate for children of 4.9%.[4]

Data from the 2005 Vermont Family Health Insurance Survey on the demographics of the uninsured in Vermont has helped to focus new policy development. Fifty-one percent (51%) of the uninsured in Vermont are eligible for a Medicaid program but are not enrolled in the program. Twenty-seven percent (27%) of the uninsured in Vermont have household income under 300% FPL but are not eligible for a Medicaid program. Twenty-two percent (22%) of the uninsured in Vermont have household income greater than 300% of FPL.

A major health care reform effort failed in Vermont in 1994 due in part to the inability of political leaders to reconcile the goal of covering the uninsured and the goal of containing costs for the insured.[5] The 2006 successful health care reform effort succeeded in part from a realization by many policy makers that the fundamental goals of health care reform are inter-related: (1) Covering the uninsured will help to lower uncompensated care costs, which affect premiums paid by the insured. (2) Unless health care costs can be brought within a more manageable rate of growth, Vermont will not be able to afford to cover the uninsured. (3) Public health initiatives and appropriate attention to healthy lifestyles and disease prevention are essential elements of an effective health care reform strategy.

---

[2] *The 2004 Vermont Health Care Expenditure Analysis can be found at http://www.bishca.state.vt.us/HcaDiv/Data_Reports/expenditure_analysis/2004EAReport.pdf.*

[3] *Hard Choices in Health Care: What Vermonters Are Thinking. Commission on the Public's Health Care Values and Priorities, BISHCA., 2002.*

[4] *Vermont Family Health Insurance Survey, 2005. The survey report can be found at http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/2005_VHHIS_Final_080706.pdf*

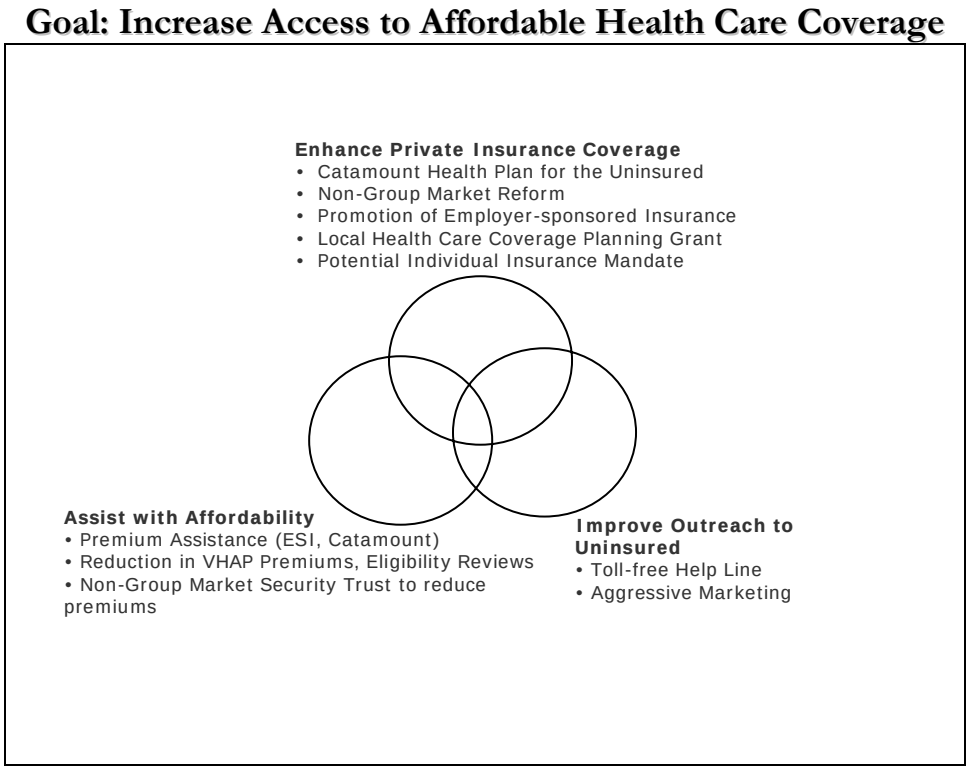
[5] *Leichter, Health Policy Reform in America: Innovations from the States. 1997.*

OVERVIEW OF FIVE-YEAR IMPLEMENTATION PLAN

Act 191 assigns responsibility to the Secretary of Administration for coordination of health care system reform among the executive branch agencies, departments, and offices in a manner that is timely, patient-centered, and seeks to improve the quality and affordability of patient care. [6]

As part of this responsibility, the Secretary is required to submit a five-year plan for implementing Vermont's health care system reform initiatives, together with any recommendations for administration or legislation, to the Governor and legislative committees [7] on or before December 1, 2006. The Secretary also is required to report annually to the General Assembly on the progress of the reform initiatives, beginning on January 15, 2007.

There are more than thirty-five separate initiatives contained in the legislation that forms Vermont's 2006 Health Care Reform agenda. All initiatives are in some way are related to all three of the health care reform goals: 1) increasing access to affordable health insurance for all Vermonters; 2) improving quality of care across the lifespan; and 3) containing health care costs. These three goals also are all related to each other. To provide a conceptual overlay of these relationships, this Strategic Plan is organized by the following framework:

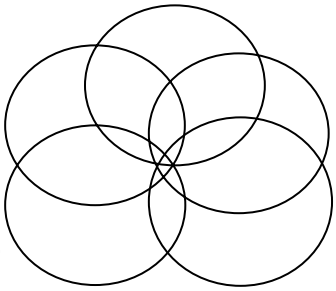


[6] *Sec. 3. 3 V.S.A. § 2222a*

[7] *To the Commission on Health Care Reform, the Health Access Oversight Committee, the House Committee on Health Care, and the Senate Committees on Health and Welfare and on Finance.*

Goal: Improve Quality of Care

Chronic Care Management
- Expand Blueprint Statewide
- OVHA Chronic Care Management Program
- Medicaid Reimbursement Incentives
- State Employee Health Plan
- ESI Premium Assistance plan approval, cost-sharing
- Catamount Health coverage, cost-sharing
- Chronic Fatigue Syndrome Information



Increase Provider Availability
- Loan Repayment Program
- Loan Forgiveness Program
- FQHC Look-alike Funding
- Uncompensated Care Pool

Promote Quality Improvement
- Consumer Health Care Price & Quality System
- Multi-payer Database
- Adverse Events Monitoring System
- Hospital-acquired Infections data
- Safe staffing reporting
- SorryWorks!
- Advanced Directives

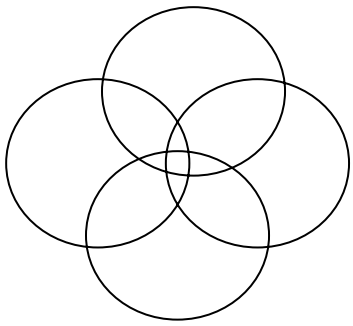
Increase Provider Access to Patient Information
- Health Information Technology
- Electronic Medical Records Loans
- Master Provider Index

Promote Wellness
- Immunizations
- CHAMPPS Grants
- Catamount Health Coverage, Cost-sharing
- Healthy Lifestyles Insurance Discounts
- AHS Inventory of Health and Wellness Programs

Goal: Contain Costs

Increased Access to Coverage and Care
→ Decreased Uncompensated Care → Lower Premium Costs

Simplify Administration
- Common Claims and Procedures
- Uniform Provider Credentialing



Decrease Cost Shift
- Increase Medicaid Provider Rates
- Cost Shift Task Force
- Standardize Policy for Hospital Uncompensated Care and Bad Debt
- Hospital Cost Shift Reporting Reforms

Improve Quality of Health Care
→ Appropriate Care → Lower Costs

Using this as a conceptual framework, this five-year plan presents a description of each of the individual health care reform initiatives; the 2011 strategic goal for that initiative; the known milestones associated with achieving the 2011 goal; the lead entity/entities within state government responsible for the milestone[8], and any statutory changes that the administration believes are needed to assist in achieving the initiative's 2011 goal.

Some of the listed milestones and dates are statutorily mandated, while others are items identified by the administration as key to successful implementation. In order to have a complete view of the milestones associated with each initiative, we have included milestones that may already have been accomplished prior to the development of this plan. Similarly, this plan will need to be adapted in future years as implementation continues and future administrative and legislative priorities emerge.

[8] *In a few instances, a non-state government entity is listed because of statutory authority for a milestone.*

2006 HEALTH CARE REFORM INITIATIVES

REFORM GOAL: INCREASE ACCESS TO AFFORDABLE HEALTH INSURANCE FOR ALL VERMONTERS

1. Enhance Private Insurance Capacity

1.1. *Catamount Health Plan.*

Act 191 created a separate insurance pool for the purpose of offering a lower cost health insurance product for uninsured[9] Vermonters. A comprehensive benefit plan will be provided under the Catamount Health Plan, which is modeled after a preferred provider organization plan with a $250 deductible and $800 out of pocket maximum for individual coverage. Cost sharing is prescribed in statute, and includes a waiver of all cost-sharing for chronic care management and services, and a zero deductible for prescription drug coverage. Lower premium costs are anticipated based on estimates concerning the claims costs of the uninsured relative to the claims costs of the general population, and based on reimbursement rates established in the law that are lower than commercial rates (but 10% higher than Medicare rates). It is expected that Catamount Health policies will be offered to the uninsured by Blue Cross Blue Shield of Vermont, MVP, and Capital District Physicians Health Plan beginning October 1, 2007. The Health Care Reform Commission will review the Catamount Health insurance plans and the Catamount Health Assistance Programs by October 1, 2009 to determine the cost-effectiveness of the program, which may trigger discussions of an alternative approach to achieve the overarching goals of the health care reform.

2011 Strategic Goal: *Have available an affordable, high quality health care plan for uninsured Vermonters.*

Milestone(s):

⚐ File expedited rules for Catamount Health that include: ▪ the process for insurance companies to follow re: individuals' dispute regarding Catamount eligibility ▪ the ability for carriers to establish a pay-for performance demonstration project ▪ rules for premium rate development	BISHCA	09/08/06 Completed
⚐ Received letters of intent from three carriers (BCBSVT, MVP, CDPHP)	BISHCA	10/07/06 Completed

[9] *Uninsured means: 1) you have insurance which only covers hospital care* OR *doctor's visits (but not both); 2) you have not had private insurance for the past 12 months; 3) you had private insurance but lost it because you lost your job, got divorced, finished with COBRA coverage, had insurance through someone else who died, are no longer a dependent on your parent's insurance, or graduated, took a leave of absence, or finished college or university and got your insurance through school; or 4) you had VHAP or Medicaid but became ineligible for those programs.*

Carrier Deadline for filing forms and rates (5 months after letter of intent)	BISHCA	03/07/07
BISHCA Deadline for approval/disapproval of carriers' forms and rates (45 days after filing)	BISHCA	04/23/07
Coordinate with AHS an aggressive enrollment strategy for Catamount Health and premium assistance	AHS/BISHCA	05/01/07
Catamount offer date	BISHCA/DCF	10/01/07
Provide monthly progress reports on Catamount Health	BISHCA/AoA	Monthly after 10/01/07
Evaluate affordability of Catamount Health Plan benefits and propose recommended changes if necessary	BISHCA/AoA	01/01/08
Re-conduct the Vermont Household Health Insurance Survey in late 2008 to assess insurance coverage and potential areas for enrolling the remaining uninsured, including eligibility for Medicaid, Catamount and/or employer-sponsored insurance	BISHCA/OVHA /DCF	10/01/08 - 12/30/08
Report # uninsured; Catamount Health costs & revenue trends, feasibility of opening Catamount at full premium cost, & # enrolled in chronic care management	BISHCA	01/15/09
Re-conduct the Vermont Household Health Insurance Survey in late 2009 to assess insurance coverage and potential areas for enrolling the remaining uninsured, including eligibility for Medicaid, Catamount and/or employer-sponsored insurance	BISHCA/OVHA /DCF	10/01/09 - 12/30/09
Evaluate Catamount Health Market re: cost effectiveness	HCR Commission	10/01/09
If legislatively required, issue RFP for Catamount Health without assumption of risk, and with state purchase of stop-loss reinsurance	AoA	01/01/10

Proposed Statutory Changes:

- The current language in 8 V.S.A. §4080f(m)(1) states that "A carrier shall notify the department that it intends to offer Catamount Health by filing written notice of that intent no later than 30 days after the effective date of the expedited adoption of Catamount Health rules." This technically prohibits a new carrier from being able to offer Catamount health in future years. The language must be revised to allow future carriers to offer the Catamount Health Plan.

- Current eligibility for Catamount Health Plans allows an individual to qualify without being uninsured for 12 months due to loss of loss of employment. It is unclear whether the General Assembly fully contemplated the effect of this on the Catamount Health Plan, the Catamount Health Premium Assistance program, or employer-based insurance if it allows individuals who retire to immediately enroll in Catamount Health Plans. The Administration proposes language to clarify this intent.

- Statutory clarification is needed to ensure that BISHCA is authorized to permit insurers to deny Catamount Health coverage to employees whose employer drops coverage solely for the purpose of enabling employees to enroll in Catamount Health Plans.

- Statutory clarification is needed regarding the standard for provider reimbursement under Catamount Health (Medicare +10% or +2%).

- Statutory clarification is needed regarding legislative intent to prohibit balance billing.

1.2. *Non-group Market Consolidation Study.*

A viable non-group market (where premiums are perceived as affordable and where enrollment is stable for all demographic groups without access to employer-sponsored insurance) is an essential component of a well-functioning, all-lines health insurance market. Like many other states, the Vermont non-group market is characterized by declining enrollment, adverse selection, increasing prices, and limited carrier participation. Act 191 directs the state to study the non-group market and make recommendations to the General Assembly to improve this option for Vermonters. The options under consideration are (1) changes to market rules; (2) consolidation of the non-group market into a single risk pool; and (3) merger of the small group and non-group markets.

2011 Strategic Goal: *The non-group market will have comprehensive products that are affordable for Vermonters, as evidenced by an increased number of available carriers and products in the non-group insurance market.*

Milestone(s):

Provide recommendations to the Legislature regarding potential reforms for the non-group market	BISHCA	01/15/07
Implement reforms approved during the 2007 legislative session	BISHCA	07/01/07
Monitor non-group market performance, and continue to make adjustments as necessary	BISHCA	On-going after 07/01/08

Proposed Statutory Changes:

- The need for statutory changes will not be known until January 2007, after completion of the study.

1.3. *Local Health Care Coverage Pilot.*

Although the state is now engaged through broad health care reform to provide and improve healthcare access and services for all Vermonters, there may be potential for other more localized models to address these concerns. Communities can play a key role in the availability of structures, facilities and services that support healthy behaviors and provide access to care. Act 191 provides funds to support a planning grant of $100,000 to one community organization or corporation to assist in establishing a local initiative to provide health care coverage or insurance to a community, region or geographic area of the state.

2011 Strategic Goal: *Locally based strategies to improve healthcare coverage and access will have been assessed and, if deemed successful, will be more broadly supported.*

Milestone(s):

Issue Community Planning Grant RFP to support a feasibility study for providing health coverage or insurance within a specified geographic region	Dept. of Health	09/20/06 Completed
Provide $100K planning grant to selected grantee	Dept. of Health	01/15/07
Written report submitted on feasibility of local coverage initiative	Grantee	06/30/07
Evaluate results of feasibility study to determine efficacy of local coverage initiative	Dept. of Health/ HCR Commission	10/01/07
If determined feasible, develop implementation recommendations for legislative consideration	Dept. of Health	01/15/08

Proposed Statutory Changes:

None.

1.4. *Individual Insurance Mandate.*

Act 191 requires that if less than 96% of Vermont's population is insured in 2010, the legislature must consider implementing a requirement that every Vermonter have health insurance.

2011 Strategic Goal: *More than 96% of Vermonters will have health insurance coverage.*

Milestone(s):

Re-conduct the Vermont Household Health Insurance Survey in late 2008 to assess insurance coverage and potential areas for enrolling the remaining uninsured, including eligibility for Medicaid, Catamount and/or employer-sponsored insurance	BISHCA/OVHA /DCF	10/01/08 - 12/30/08

Using the 2008 survey as a guide, propose new initiatives to increase insurance coverage for Vermonters.	Administration	01/15/09
Re-conduct the Vermont Household Health Insurance Survey in late 2009 to assess insurance coverage and potential areas for enrolling the remaining uninsured, including eligibility for Medicaid, Catamount and/or employer-sponsored insurance	BISHCA/OVHA /DCF	10/01/09-12/30/09
Report on insurance coverage to the General Assembly	BISHCA	01/01/10
Using the 2009 survey as a guide, propose new initiatives to increase insurance coverage for Vermonters.	Administration	01/01/10
Legislative decision about individual mandate	General Assembly	2010 Session

Proposed Statutory Changes:
None.

2. Provide Assistance with Insurance Affordability

2.1. *Catamount Health Premium Assistance Program*.

A Vermont resident who has been uninsured for at least 12 months, who is not eligible for a public insurance program such as Medicaid, and who does not have access to an approved employer-sponsored insurance plan[10] may apply for financial assistance to purchase a Catamount Health policy at the following rates:

Under 200% FPL:	$60 per month
200-225% FPL:	$90 per month
225-250% FPL:	$110 per month
250-275% FPL:	$125 per month
275-300% FPL:	$135 per month
Over 300% FPL:	full cost of the Catamount Health policy (approx. $360)

2011 Strategic Goal: *Uninsured Vermonters with low incomes will have access to Catamount health insurance offerings.*

Milestone(s):

Submit waiver amendment request to CMS to implement Catamount premium assistance program	AHS/OVHA	09/11/06 Request Submitted

[10] *At minimum, an approved employer-sponsored insurance plan for Catamount ESI Premium Assistance would be required to conform to the following standards: 1)the benefits covered by the plan must be substantially similar to the benefits covered under Catamount Health; 2) appropriate coverage of chronic conditions in a manner consistent with statewide participation by health insurers in the Vermont Blueprint for Health; and 3) after statewide participation is achieved, coverage of chronic conditions substantially similar to Catamount Health.*

Establish rules for Catamount premium assistance program to include: ▪ Specific criteria for eligibility ▪ Individual and family contribution amounts (adopt amounts specified in Title 33 §1984) ▪ Grievance process	DCF	07/01/07
Initiate comprehensive education and enrollment strategy for Catamount Health and premium assistance (see 3.1)	Administration	05/01/07
Implement Catamount Premium Assistance Program	DCF/OVHA	10/01/07
Establish grievance process re: premium assistance eligibility	DCF	10/01/07
Report on projected Catamount premium assistance enrollees and costs to Emergency Board	DCF/OVHA	Semi-annually (Jan. & July)
Emergency Board review of cost compared to available resources; potential decision to suspend new enrollment	E-Board	Semi-annually (Jan. & July)
Evaluate effectiveness of Catamount Health Plan premium assistance levels and propose recommended changes if necessary	OVHA/BISHCA	01/01/08

Proposed Statutory Changes:

- 33 V.S.A. §1985(b) states "an individual applying for or enrolled in the program established under this subchapter who is aggrieved by an adverse decision of the agency may grieve or appeal the decision under rules and procedures consistent with 42 CFR §438.402." The citation is to the global commitment grievance process, but this process is only for coverage grievances, not eligibility grievances. The statute needs to be changed to refer to the fair hearing process that AHS uses for eligibility disputes.

- The Statute has a discrepancy regarding income levels related to premium assistance. 33 V.S.A. §1974(c)(2)(B) states that coverage is available to individuals with incomes under 300% of FPL, but the language in 33 V.S.A. §1984(c)(5) regarding monthly premiums specifies a premium of $135 for individuals with incomes greater than 275 percent and less than or equal to 300%." The language needs to be changed to consistently reference "under 300%."

- The Administration believes that Act 191 intended to create an integrated system of state assistance programs to better assure the continuity of health care to covered beneficiaries. To this end, we believe that the legislative intent was that individuals who fall out of one assistance category may transition into another when eligibility requirements are met. (See Appendix B for a graphic of possible transitions). However, not all of these possible transitions are sanctioned in statute.[11] We propose the following three statutory additions to assure clear authority for each of the identified transitions:

[11] I*nitial transitions from Medicaid and VHAP into Catamount Health or ESI and transitions from one of the new programs back into Medicaid are all expressly contemplated in the law.*

Insert as new paragraph (d) in 33 V.S.A. § 1974: If, after enrollment in a premium-assistance program described in paragraph (a) or (b) of this section, the individual's eligibility for the Vermont health access plan should change, the individual's premium-assistance program enrollment shall be modified accordingly.

Insert as new paragraph (e) in 33 V.S.A. § 1974: Individuals who have Catamount Health or who are enrolled in the Catamount Health Assistance Program may be enrolled in an employer-sponsored premium assistance program without being uninsured for 12 months.

Insert as new subparagraph (a) (4) in 33 V.S.A. § 1983: Individuals who have Catamount Health may be enrolled in the Catamount Health Assistance Program without being uninsured for 12 months.

- The premium payment amounts for Catamount Health are defined in statute at a fixed amount with no inflationary increases over time. The Administration believes that these rates should be adjusted annually based on a nationally-recognized cost of living index.

2.2. *Employer Sponsored Insurance (ESI) Premium Assistance Program.*

If cost-effective for the state, adults currently enrolled in the Medicaid VHAP program and new VHAP applicants who have access to an approved employer-sponsored insurance (ESI) plan[12] will be required to enroll in the employer-sponsored plan as a condition of continued premium assistance or coverage under VHAP. The premium assistance program will provide a subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual to ensure that the individual out-of-pocket obligations for premiums and cost-sharing amounts are substantially equivalent to or less than the annual premium and cost-sharing obligations under VHAP. In addition, supplemental benefits or "wrap-around" coverage will be offered to ensure VHAP enrollees continue to receive the full scope of benefits available under VHAP.

The ESI Premium Assistance Program also will make health coverage more affordable for uninsured low-income Vermonters who are not eligible for Medicaid or VHAP, have incomes under 300 percent FPL, and who have access to an approved employer-sponsored coverage. The ESI Premium Assistance Program will provide a subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual, with greater amounts of financial assistance provided to eligible individuals with lower household income and lesser amounts of assistance provided to eligible individuals with higher household income. However, if providing the individual with assistance to purchase Catamount Health is more cost-effective to the State than providing the individual with premium assistance to purchase the individual's approved employer-sponsored plan, the State shall enroll the individual in the Catamount Health Assistance Program.

[12] *At minimum, an approved employer-sponsored insurance plan for VHAP-ESI Premium Assistance would be required to conform to the following standards: 1)the benefits covered by the plan must be substantially similar to the benefits covered under the certificates of coverage offered by the typical benefit plans issued by the four health insurers with the greatest number of covered lives in the small group and association market in the State, and 2) the plan must include appropriate coverage of chronic conditions in a manner consistent with statewide participation by health insurers in the Vermont Blueprint for Health.*

2011 Strategic Goal: *Uninsured Vermonters with low incomes will have access to their employer's health plans.*

Milestone(s):

Submit waiver amendment request to CMS to implement ESI premium assistance program	AHS/OVHA	09/11/06 Request Submitted
Conduct survey of people currently enrolled in VHAP to assess eligibility for ESI	OVHA/DCF	11/01/06 Completed
Submit ESI implementation/fiscal report to HAOC and JFC that contains estimated ESI premium, cost-sharing amounts, and wrap benefits, plan for kids, projected FY08 budget impact; enables expenditures above initial $250,000	OVHA/DCF	11/22/06 Completed
HAOC/JFC joint meeting to approve expenditure of remaining $750,000 for implementation of the ESI program	HAOC/JFC	12/12/06
Determine whether to include children if parents choose to do so	OVHA	03/15/07
Initiate aggressive education and strategy for ESI premium assistance (see 3.1)	Administration	05/01/07
Establish rules for ESI premium assistance programs to include: ▪ Specific criteria for eligibility ▪ Criteria for approving ESI plans for Catamount eligibles– must be consistent with Catamount Health ▪ Criteria for approving ESI plans for VHAP eligibles – must be consistent with typical plan of 4 largest small group & association insurers ▪ Criteria for assessing cost effectiveness of ESI premium assistance versus VHAP enrollment ▪ Criteria for assessing cost effectiveness of ESI versus Catamount Health premium assistance ▪ Process for over-payment recovery ▪ Grievance process	DCF/OVHA	07/01/07
Implement ESI premium Assistance Program	DCF/OVHA	10/01/07
Report on number enrolled, income levels, description of approved ESI plans, employer cost related to premium assistance program, and net savings of program. [13]	DCF/OVHA	Monthly after 10/01/07

[13] *Report must be submitted to the Health Access Oversight Committee, the Joint Fiscal Committee, and the Health Care Reform Commission.*

Evaluate effectiveness of ESI premium assistance levels and propose recommended changes if necessary	Administration	01/01/08
Explore extending ESI Premium assistance to other Medicaid enrollees.	OVHA	01/01/08
Report on projected ESI premium assistance enrollees and costs to Emergency Board	DCF/OVHA	Semi-annually (Jan. & July)
Emergency Board review of cost compared to available resources; potential decision to suspend new enrollment	E-Board	Semi-annually (Jan. & July)
Re-conduct the Vermont Household Health Insurance Survey in late 2008 to assess insurance coverage and potential areas for enrolling the remaining uninsured, including eligibility for Medicaid, Catamount and/or employer-sponsored insurance	BISHCA/DCF /OVHA	10/01/08 - 12/30/08
Using the 2008 survey as a guide, propose new initiatives to increase insurance coverage for Vermonters.	Administration	01/15/09
Re-conduct the Vermont Household Health Insurance Survey in late 2009 to assess insurance coverage and potential areas for enrolling the remaining uninsured, including eligibility for Medicaid, Catamount and/or employer-sponsored insurance	BISHCA/DCF /OVHA	10/01/09 - 12/30/09
Using the 2009 survey as a guide, propose new initiatives to increase insurance coverage for Vermonters.	Administration	01/01/10

Proposed Statutory Changes:

- To assist with smooth transition, eligibility for VHAP should be a "qualifying event" that allows an individual to enroll in their employer-sponsored insurance (ESI) outside of the employer's open enrollment period. Therefore, we propose adding language that provides BISHCA with the statutory authority to adopt rules requiring carriers to allow this provision.

2.3. *Decrease VHAP Premiums and Medicaid Eligibility Reviews.*

It is believed that the cost of premiums has a direct effect on level of enrollment in the VHAP program. Effective July 1, 2007, premiums for children enrolled in the Medicaid Dr. Dynasaur program will be decreased by 50% and premiums for adults in the Medicaid VHAP program will be decreased by 35%.

2011 Strategic Goal: *All eligible Vermonters will be enrolled in VHAP and Dr. Dynasaur.*

Milestone(s):

Report on dis-enrollment in each of the Medicaid programs subject to premiums, with # of beneficiaries terminated from coverage for non-payment [14]	DCF/OVHA	Quarterly
Reduce premium payments for individuals enrolled in Dr. Dynasaur and SCHIP	DCF	07/01/07
Reduce premium payments for individuals enrolled in VHAP	DCF	07/01/07
Increase eligibility recertification or reapplication for Medicaid programs from every 6 months to every 12 months	DCF	10/01/07

Proposed Statutory Changes:

- The Administration believes that the premium amounts for VHAP should be adjusted annually based on a nationally-recognized cost of living index.
- Others changes to premium amounts to be determined annually by Governor's proposed budget and the General Assembly's appropriation to ensure financial stability of the Medicaid, VHAP and Dr. Dynasaur programs.

2.4. *Non-group Market Security Trust.*

Act 191 directed BISHCA to establish a non-group market security trust to lower the cost of health care and thereby increase access to health care for Vermonters. The purpose of this trust is to reduce premiums in the non-group market by a minimum of 5% to make non-group products more affordable for individual Vermonters. State funds have been committed to this Trust, and Vermont also has been awarded a federal grant from CMS for start-up expenses and may have the opportunity to seek additional federal funds for operating expenses.

2011 Strategic Goal: *The non-group market will have comprehensive products that are affordable for Vermonters, as evidenced by reduced enrollee costs in the non-group insurance market.*

Milestone(s):

Applied for federal grant to assist with implementation	BISHCA	07/01/06 Completed
Received federal grant to assist with implementation	BISHCA	10/06/06 Completed

[14] *Report must be submitted to the House and Senate committees on Appropriations, the Senate Committee on Health and Welfare, the House Committee on Human Services, the Health Access Oversight Committee, , and the Medicaid Advisory Board..*

Develop rules and design trust	BISHCA	07/01/07
Monitor non-group market affordability, and continue to make adjustments as necessary	BISHCA	On-going after 07/01/08

Proposed Statutory Changes:
None.

3. Improve Outreach to Uninsured

3.1. *Comprehensive Outreach and Enrollment Strategy.*

Act 191 calls for the Agency of Human Services to implement an aggressive outreach campaign and toll-free help-line to assist individuals with Catamount Health and the premium assistance programs. The toll-free help-line will augment the already-existing toll-free help line for Medicaid, VHAP and Dr. Dynasaur. In addition, Act 191 authorizes the Bi-State Primary Care Association to produce a report with recommendations regarding improved outreach and enrollment strategies for Medicaid; the purview of this report was expanded to include Catamount Health at the request of the Administration. The Administration recognizes that the goals of the 2006 Health Care Reform will be successful only if outreach and enrollment is a priority. As such, the Administration has started working with Bi-State and other Vermont stakeholders to develop a comprehensive marketing strategy across all the coverage and affordability initiatives.

2011 Strategic Goal: *More than 96% of Vermonters will have health insurance coverage.*

Milestone(s):

Bi-State Primary Care Association Report on outreach and enrollment strategies	Bi-State	11/15/06 Completed
Using the Bi-State report as a foundation, develop a comprehensive outreach and enrollment strategy across the continuum of solutions for the uninsured, using a unified marketing campaign with specialized messages for specific uninsured populations and broader audiences (e.g., employers, clergy)	Administration	01/15/07
Pursue foundation funding to assist with refinement of, and funding for, comprehensive outreach and enrollment strategy	AoA	01/15/07
Establish toll-free help line re: enrollment and premium assistance	AHS	05/01/07
Using Bi-State report as a foundation, develop tools to assist with outreach and enrollment	Administration	05/01/07

⚑ Re-conduct the Vermont Household Health Insurance Survey in late 2008 to assess insurance coverage and potential areas for enrolling the remaining uninsured, including eligibility for Medicaid, Catamount and/or employer-sponsored insurance	BISHCA/DCF /OVHA	10/01/08 - 12/30/08
⚑ Using the 2008 survey as a guide, develop targeted outreach and enrollment strategies for existing uninsured populations	Administration	01/15/09
⚑ Re-conduct the Vermont Household Health Insurance Survey in late 2009 to assess insurance coverage and potential areas for enrolling the remaining uninsured, including eligibility for Medicaid, Catamount and/or employer-sponsored insurance	BISHCA/DCF /OVHA	10/01/09 - 12/30/09
⚑ Using the 2009 survey as a guide, develop targeted outreach and enrollment strategies for existing uninsured populations	Administration	01/01/10

Proposed Statutory Changes:
None.

REFORM GOAL: IMPROVE QUALITY OF CARE ACROSS THE LIFESPAN

---

4. Improve Chronic Care Management

4.1. *Blueprint for Health – the State's Chronic Care Plan.*

Chronic conditions are the leading cause of illness, disability, and death in Vermont. More than half of all Vermont adults have one or more chronic conditions (e.g., diabetes, hypertension, cardiovascular disease, asthma, arthritis, cancer, respiratory diseases, depression and other mental health disorders, substance dependence and many others). Caring for Vermonters with chronic conditions consumes more than three-quarters of the funds spent in the state each year on health care.[15] As such, Vermont has decided to invest significant public funds in the redesign of our state's health system to improve the quality and cost-effectiveness of preventing chronic conditions and providing care for those with chronic conditions.

Launched in 2003 by Governor James Douglas as a public–private partnership, the Blueprint for Health was fully endorsed in Act 191 of 2006 as Vermont's plan to have a systemic statewide system of care that

[15] *It is estimated that in excess of $2.3 billion was spent on chronic conditions in Vermont in 2002, including approximately $407 million in Medicaid spending. Vermont Health Care Expenditure Analysis 2002. Vermont Dept. of Banking, Insurance, Securities, and Health Care Administration.*

improves the lives of individuals with, and at risk for, chronic conditions.[16] The Blueprint model targets six change areas:

- *Individual Vermonters.* People will have the knowledge, skills and supports needed to actively manage and be responsible for his or her own care and make healthier choices.
- *Provider Practice Team.* Vermonters will receive care consistent with evidence-based standards, and their providers will have the training, tools and financial incentives to ensure treatment consistent with those standards.
- *Communities.* Communities will become engaged in public health at the local level to address physical activity, nutrition, and other behaviors to prevent or control chronic diseases.
- *Information Technology.* A Chronic Care Information System, coordinated with the Health Information Technology Plan (see 5.1), will be developed that supports statewide implementation of the Blueprint for both individual and population based care management.
- *Health System.* The Blueprint collaborative will develop common performance measures and clinical guidelines for chronic conditions, improve systems coordination and link financing mechanisms and insurance reimbursement with the attainment of chronic care treatment goals.
- *Public Health Systems.* Health promotion and public policy initiatives, modeled on the successful tobacco control programs, will address the environmental changes essential to supporting individuals, providers, communities and the health system make and sustain the needed changes.

The Blueprint initially focused on two Vermont communities, and is expanding to several more in 2007. Act 191 requires that the Blueprint be implemented statewide by 2009, and that other chronic care initiatives within the reform package (described below) align with the Blueprint priorities and projects. It also requires that the Blueprint have its own Strategic Plan; therefore this Health Care Reform Implementation Plan provides only provides highlights of the proposed Blueprint implementation. More detailed information on implementation of the Blueprint can be found at http://healthvermont.gov/blueprint.aspx .

2011 Strategic Goal: *Vermont has a systemic statewide system of care that improves the lives of individuals with, and at risk for, chronic conditions, as evidenced by better management of chronic conditions, reduction in the risk factors associated with developing chronic diseases and/or their complications, and reduced growth in health care costs.*

Milestone(s):

Establish executive advisory committee for five-year plan	Dept. of Health	05/25/06 Completed
Submit preliminary report on Blueprint organizational structure	Dept. of Health	06/15/06 Completed
Provide incentive grants & stipends to physician practices participating in Blueprint pilots	Dept. of Health	07/01/06 Completed
Present interim revised Blueprint strategic plan that includes 1/1/07 target for full IT model design	Dept. of Health	10/01/06 Completed
Present final 5-year strategic plan, report on implementation status and amendments	Dept. of Health	01/01/07

Include within 5-year strategic plan alignment of IT needs with other health care IT initiatives and complete design for chronic care IT model	Dept. of Health	01/01/07
Develop AHS implementation plan for prevention and management of chronic conditions; modify as needed to reflect changes in Blueprint Strategic Plan	Dept. of Health OVHA/AHS	01/01/07 and on-going
Tie Medicaid reimbursement for hospitals & health care professionals to Blueprint standards and performance standards	OVHA	07/01/07
Expand Blueprint communities and diseases as resources allow	Dept. of Health	07/01/08 and on-going
Statewide Blueprint participation deadline – recommend changes if not achieved	Dept. of Health	01/01/09

Proposed Statutory Changes:

- 18 V.S.A. §702(b) (1) establishes the Blueprint Executive Committee and its membership. In doing so, it designates that the Executive committee shall have a representative from the Vermont Program for Quality in Health Care (VPQHC), which is also a potential (and current) grantee of the Blueprint. To eliminate an explicit conflict of interest required by statute, the State recommends that this statutory reference be changed to a representative from "a statewide quality assurance organization."

4.2. *OVHA Chronic Care Management Program (CCMP).*

Act 191 requires that the Office of Vermont Health Access (OVHA), the state's Medicaid agency, develop a Chronic Care Management Program for Vermonters enrolled in Medicaid, Dr. Dynasaur and VHAP, through a contract with a private company and consistent with the policies and standards established by the Blueprint for Health.

2011 Strategic Goal: *All Medicaid, Dr. Dynasaur, and VHAP beneficiaries living with a chronic condition will receive health care services that are based on nationally recognized clinical best-practice guidelines for health treatments and self care.*

Milestone(s):

Analyze need for Medicaid waiver for Chronic Care Management Program & include in waiver amendment request to CMS	OVHA/AHS	09/11/06 Completed
HCR Commission approval of RFP before it is issued	OVHA	10/06/06 Completed
Select vendor for Chronic Care Management Program	OVHA	02/15/07
Fill 3 new positions for Chronic Care Management RFP &	OVHA	06/01/07

on-going contract management

Implement Chronic Care Management Program	OVHA	07/01/07
Modify program as needed to align with Blueprint	OVHA	07/01/07 and On-going

Proposed Statutory Changes:

- 33 V.S.A. §1903a (7) requires the care management vendor's fee to be at risk for guaranteed savings. This full risk concept for an independent vendor is at odds with the goal of the Blueprint, where the patient and the provider are seen as key to successful goal attainment. In addition, research indicates that "guaranteed savings" contracts may not be advantageous for the State. As such, the State proposes to amend this section to permit only portions of the contract to be at financial risk.

4.3. *Medicaid Reimbursement Incentives for Participating in CCMP.*

OVHA also is mandated to determine how to restructure payment to health care professionals for chronic care to pay doctors to provide the right care at the right time. They also will provide incentive payments to health care professionals participating in the Medicaid care coordination program; and reimbursement increases in the future will be tied to performance measures established by the Blueprint for Health - the Chronic Care Initiative.

2011 Strategic Goal: *Provider reimbursements will facilitate providers' efforts to meet the Blueprint and Chronic Care Management program standards.*

Milestone(s):

Develop incentives & payment restructuring for health care professionals participating in care coordination management program	OVHA	07/01/07[17]
Develop proposals to tie Medicaid reimbursement for hospitals & health care professionals to Blueprint standards and performance standards	OVHA	01/01/09[18]

Proposed Statutory Changes:

- Propose amendment to statutory timeframe to align with OVHA's Chronic Care Management Program and the statewide implementation of Blueprint.

4.4. *State Employee Health Benefits Program Alignment with Blueprint.*

[17] *The statutory timeframe for this milestone is 01/01/07; however, the OVHA chronic care management program is not projected to begin until 07/01/07.*

[18] *The statutory timeframe for this milestone is 07/01/07; however, the Blueprint is not expected to be statewide until 01/01/09. As such, proposals for tying Medicaid provider payments to Blueprint standards should be considered after the Blueprint is statewide.*

The state's self-insured health care plan for employees was required to include alignment with the Blueprint as a component of the contract re-bid process in 2006.

2011 Strategic Goal: *All state employees living with or at risk of developing a chronic condition will receive health care services that are based on nationally recognized clinical best-practice guidelines for health treatments and self care.*

Milestone(s):

Ensure that the State Employee Health Benefits Program that begins in January 2007 includes a Chronic Care Management Program and alignment with the Blueprint principles	DHR	01/01/07 Completed
Ensure that the selected carrier engages in Blueprint leadership committees	DHR	01/01/07 and On-going
Evaluate effectiveness of State Employee Health Benefits program chronic care management services	DHR	01/01/09
Ensure that the State Employee Health Benefits Program that begins in January 2010 includes a Chronic Care Management Program and alignment with the Blueprint principles	DHR	01/01/10

Proposed Statutory Changes:
None.

4.5. *Employer-Sponsored Insurance (ESI) Premium Assistance Chronic Care Coverage.*

ESI plans approved by the state for the premium assistance programs must include chronic care coverage consistent with Blueprint. In addition, the state's premium assistance program will cover all chronic care cost-sharing amounts for beneficiaries enrolled in a Chronic Care Management Program.

2011 Strategic Goal: *All participants in ESI premium assistance will have access to chronic care treatment.*

Milestone(s):

Establish the criteria to be used to evaluate whether ESI plans have appropriate chronic care coverage	OVHA	01/15/07
Implement the administrative processes to pay chronic care cost-sharing for beneficiaries enrolled in a Chronic Care Management Program.	OVHA	10/01/07

Proposed Statutory Changes:

- The standard for approving and wrapping VHAP ESI plans for chronic care in section 13 of Act 191 is inconsistent with other sections related to chronic care in Act 191(Sections 5, 6, 7, and 15). The standard should be consistent across all the programs. 33 V.S.A. §1974(c) (3) should be

amended to read: "Until an approved employer-sponsored plan is required to meet the standard in subdivision (4) (B) (ii) of this subsection, the subsidy shall include premium assistance and assistance to cover all cost-sharing amounts for ~~chronic care~~ participation in chronic care management, consistent with the criteria and requirements of chapter 13 of Title 18 and section 1903a of Title 33."

- Consistent with legislative intent that the Blueprint guide the state's chronic care management implementation, the Administration believes that the standards to be used for approving Chronic Care Management Programs within ESI plans should be determined by Blueprint Executive Committee.

4.6. *Catamount Health Plan Chronic Care.*

Carriers offering Catamount Health Plans are required to have a Chronic Care Management Program available to their Catamount health beneficiaries, and must waive cost-sharing for beneficiaries that are actively participating in those Chronic Care Management Programs.

2011 Strategic Goal: *All Catamount Health Plans will include Chronic Care Management Programs and those programs will waive cost-sharing for beneficiaries that actively participate.*

Milestone(s):

Include requirement in Catamount Health rules	BISHCA	09/08/06 Completed
Catamount Health Chronic Care Management Programs must be filed with the State (5 months after letter of intent)	BISHCA	03/07/07

Proposed Statutory Changes:
None.

4.7. *Chronic Fatigue Syndrome Informational Packets.*

The Vermont Department of Health was required to prepare and distribute an informational packet to health care providers, and make such information available to the public, to broaden understanding and awareness of this debilitating condition.

2011 Strategic Goal: *Vermont health care providers and the general public will have easy and ready access to current information on the diagnosis, treatment, and available resources for Chronic Fatigue Syndrome to improve the quality of life for those affected by this serious and debilitating condition.*

Milestone(s):

Put Chronic Fatigue Syndrome information on Department of Health web-site	Dept. of Health	11/01/06 Completed

⚐ Inform health care providers of the information available on the web-site through publication of an article in the Disease Control Bulletin.	Dept. of Health	12/30/06
⚐ Use the Vermont Health Alert Network to inform family practice, internal medicine, pediatric and OB/GYN providers of the information available on the web-site.	Dept. of Health	12/30/06

Proposed Statutory Changes:
None.

5. Increase Provider Access to Patient Medical Information

5.1. *Health Information Technology.*

The Health Care Reform financially supports the Vermont Information Technology Leaders (VITL), a public-private partnership, as the entity to develop the statewide, integrated, electronic health information infrastructure for the sharing of health information among health care facilities, health care professional, public and private payers, and patients. As a first step, the Medication History Pilot Project will reduce the risk of adverse drug events; improve the quality of health care for many Vermonters, and save health care costs. VITL also is the conduit for the Chronic Care Management Information System to support the Blueprint for Health. The legislation also requires that VITL develop a State Health Care Information Technology Plan to address issues related to data ownership, governance, and confidentiality and security of patient information.

2011 Strategic Goal: *All Vermont providers will be able to share real-time clinical information with other providers across the state to improve patient outcomes, reduce service duplication, and decrease the growth of health care costs, while ensuring patient confidentiality.*

Milestone(s):

⚐ VITL progress report on health care information technology (HC IT) coordination	VITL/BISHCA	Annually
⚐ Secretary of Administration approval of VITL plan to coordinate with Blueprint and delivery of sustainable business plan to Secretary of Administration and Legislature	VITL/AoA	07/01/06 Completed
⚐ VITL submission of preliminary Health Information Technology Plan	VITL/BISHCA	01/01/07
⚐ Medication History Project implemented at first two sites - Regional Medical Center and Northeastern Vermont Regional Hospital	VITL	03/01/07

Implementation of first community site - Mt. Ascutney - for the Blueprint Chronic Care Information System (CCIS)	VITL /Dept. of Health	06/01/07
VITL submission of final Health Information Technology Plan	VITL/BISHCA	07/01/07
Continue to expand VITL capacity to develop statewide infrastructure	VITL	On-going
Assure IT components of Blueprint, OVHA Global Clinical Record, and other HC IT projects are incorporated into and comply with Statewide Health Information Technology Plan (VITL) & DII Initiatives	AHS	On-going
Assure IT components of VPQHC quality assurance system are incorporated into and comply with Statewide Health IT Plan (VITL) and DII Initiatives	VITL	On-going

Proposed Statutory Changes:

- Statutory changes may be needed to facilitate physician provision of information into the chronic care information system.

5.2. *Master Provider Index for Vermont Health Care Professionals.*

A work group of the Area Health Education Centers (AHEC) Program of the University of Vermont College of Medicine is charged with developing recommendations about how to create a master provider index to ensure uniform and consistent identification and cross reference of all Vermont health care professionals for information technology purposes.

2011 Strategic Goal: *Vermont will have a health technology infrastructure that enables provider cross-referencing to facilitate better health care services and cost effectiveness.*

Milestone(s):

Convene work group to make Master Provider Index recommendations	AHEC	09/01/06 Completed
Report to Legislature regarding creation of Master Provider Index	AHEC	01/15/07
Implement report recommendations adopted by the General Assembly, within available resources	AoA	07/01/07 and On-going

Proposed Statutory Changes:

None.

5.3. *Loan Program for Physician Electronic Medical Records Infrastructure.*

The legislation requires that the State develop a loan and grant program for electronic medical records at primary care practices, and that implementation be a component of the VITL State Health Care Information Technology Plan.

2011 Strategic Goal: *All Vermont Health Care providers, hospitals, insurers and the state have access to a comprehensive health information system in order to improve the quality and cost-effectiveness of the state's health care.*

Milestone(s):

Explore availability of low interest loans through federal or private organizations as complementary or alternative to state funding.	VDH/VITL	01/01/07
Establish a loan & grant program for electronic medical records at primary care practices; implementation plan must be in Health IT Plan	VDH/VITL	07/01/07

Proposed Statutory Changes:

- Act 215 created the mandate for BISHCA to develop this program in consultation with other state departments and agencies and VITL, but did not include an appropriation. The Administration believes that this program would be more properly aligned with the Blueprint implementation and proposes that the Department of Health be given the statutory authority to implement this program as resources are made available.

6. Promote Wellness

6.1. *Free Immunizations.*

Starting October 1, 2007, clinically recommended immunizations will be provided to all Vermonters across the lifespan at no cost when not otherwise reimbursed.

2011 Strategic Goal: *All Vermonters will have access to all ACIP*-Recommended Immunizations. (Advisory Committee on Immunization Practices of the Centers for Disease Control)*

Milestone(s):

Establish Immunization Advisory Committee	Dept. of Health	11/01/06 Completed
Study and make recommendations re: methods to ensure universal access to immunizations	Dept. of Health	01/15/07
Implement report recommendations	Dept. of Health	10/01/07
Ensure access to immunizations at no cost to individual	Dept. of Health /OVHA	10/01/07

Proposed Statutory Changes:

- As it is currently written, the following sentence in 18 V.S.A. §1130(b) would violate the federal requirement that Medicaid be the payer of last resort:: The department shall be the secondary payer to Medicaid, the Vermont health access plan, Dr. Dynasaur, Medicare, and any federal health insurance or federal program covering immunizations. We propose the following language to meet federal requirements and to ensure that we maximize federal participation: The department shall be the payer only for those residents not enrolled in Medicaid, the Vermont health access plan, Dr. Dynasaur, Medicare, or any federal health insurance or federal program covering immunizations.

6.2. *CHAMPPS (Coordinated Healthy Activity, Motivation and Prevention Program)*.

Vermont has recognized that public health concerns such as those relating to overweight and poor nutrition are major drivers in the incidence of chronic disease incidence and in increased medical inflation. CHAMPPS will provide competitive multi-year grants to communities to assist them in promoting healthy behavior and disease prevention across the lifespan of the individual, consistent with the Blueprint and community goals. Examples include the promotion of good nutrition and exercise for children, community recreation programs, elderly wellness, lead poisoning abatement, obesity prevention, mental health promotion and substance abuse prevention, maternal and child health and immunization, and tobacco prevention and cessation programs.

2011 Strategic Goal: *Comprehensive community prevention grants will support a holistic approach to promoting community health and the prevention of leading causes of disease.*

Milestone(s):

Establish community grants committee	Dept. of Health	09/01/06 Completed
Report to Legislature on inventory of state wellness initiatives and funding	Dept. of Health /AHS	12/15/06
Report to Legislature on status of community grants program	Dept. of Health	01/15/07
Date for grant awards to begin	Dept. of Health	07/01/07

Proposed Statutory Changes:

None.

6.3. *Catamount Health Plan Preventative Care.*

The Catamount Health Plans are required to include coverage for preventive care and carriers must waive cost-sharing for preventive care. Preventive care includes immunizations, screening, counseling, treatment and medication determined by scientific evidence to be effective in preventing or detecting a condition.

2011 Strategic Goal: *All Catamount Health Plans will include coverage for preventative care and waive cost–sharing related to preventive care.*

Milestone(s):

⚐ Include requirement in Catamount Health rules	BISHCA	09/08/06 Completed
⚐ Ensure that preventative care is incorporated into carrier coverage forms (5 months after letter of intent)	BISHCA	03/07/07

Proposed Statutory Changes:
None.

6.4. *Healthy Choices Insurance Discount.*

The Catamount Health legislation authorizes the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to adopt regulations permitting health insurers to establish premium discounts (up to 15% of premiums) or other economic rewards for insured's in Vermont's community rated non-group and small group markets. Premium discounts will be available for those who participate in programs of health promotion and disease prevention.

2011 Strategic Goal: *Facilitate the implementation of pricing structures in the private health insurance market which will encourage Vermonters to make healthy lifestyle choices and improve overall health quality.*

Milestone(s):

⚐ Establish rules to permit carriers, et. al. to establish wellness rewards for enrollees	BISHCA Dept. of Health OVHA	05/30/07

Proposed Statutory Changes:
None.

7. Increase Provider Availability

7.1. *Educational Loan Repayment Program.*

Recognizing the need to attract and retain providers working in underserved areas (specialties or geographic) or with underserved populations, the legislation authorizes awards to Vermont health care providers and faculty educators that meet these criteria who have outstanding educational loans, with the agreement that they will serve patients with Medicare, Medicaid, or state health benefit coverage, if applicable.

2011 Strategic Goal: *Vermont will have a sufficient number of health professionals in all communities to meet the healthcare access needs of all Vermonters.*

Milestone(s):

⚐ New fund established to help recruit and retain health care providers and educators in underserved geographic and specialty areas	Dept. of Health AHEC	09/15/06 Completed

Proposed Statutory Changes:
None.

7.2. *Educational Loan Forgiveness Program.*

The legislation augments an existing educational loan forgiveness program for dental hygienists and nurses, two specialties that are hard to recruit and retain in Vermont.

2011 Strategic Goal: *Vermont will have an adequate supply of dental hygienists and nurses to meet the needs of our population.*

Milestone(s):

⚐ Augment funding for existing educational loan forgiveness program for dental hygienists and nurses	Dept. of Health VSAC	09/15/06 Completed

Proposed Statutory Changes:
None.

7.3. *Funds for FQHC Look-alikes.*

Uncompensated care pool funds were designated for an income-sensitized sliding scale fee schedule for patients at FQHC look-alikes to provide equal geographic distribution of funds.

2011 Strategic Goal: *Vermont will have a FQHC look-alike or FQHC in every county.*

Milestone(s):

⚐ Fund FQHCs look-alikes to develop income-sensitive sliding scale fees	Dept. of Health	12/15/06

Proposed Statutory Changes:
None.

8. Promote Quality Improvement

8.1. *Consumer Price and Quality Information System.*

A major factor in the success of consumer driven health care plans is consumer access to good price and quality information. This is especially important as more benefit plans require higher levels of out of pocket spending. The Health Care Reform legislation directs the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to adopt rules for health insurers to provide transparent price and quality information so that consumers are empowered to make economically sound and medically appropriate decisions.

2011 Strategic Goal: *Vermont insurers, providers, consumers and state regulators will work together to ensure that health care consumers have access to accurate, understandable and reliable health care price and quality information.*

Milestone(s):

Establish advisory Consumer Price and Quality Transparency Work Group	BISHCA	10/31/06 Completed
Initiate rulemaking to require insurers and other participants in the health care system to make price and quality information available to consumers	BISHCA	04/30/07
Complete rulemaking to require insurers and other participants in the health care system to make price and quality information available to consumers	BISHCA	01/01/08
Begin data collection to inform system to make price and quality information available to consumers	BISHCA	01/31/08
Provide price and quality information to consumers.	BISHCA	07/01/08
Continue to expand price and quality system as new data becomes available.	BISHCA	On-going

Proposed Statutory Changes:

None.

8.2. *Multi-payer Data Collection Project.*

Health care providers, hospitals, insurers and the state need a comprehensive health information system in order to improve the quality and cost-effectiveness of the health care system. Modeled after programs in Maine and New Hampshire, BISHCA is directed to design the health insurance claims data collection program and to begin program implementation.

2011 Strategic Goal: *All Vermont health care providers, hospitals, insurers and the state have access to a comprehensive health information system in order to improve the quality and cost-effectiveness of the state's health care.*

Milestone(s):

Implement pilot initial registration of TPAs and PBMs to test the registration process and proposed draft registration form.	BISHCA	01/31/07
Establish rules for registration of non-licensed entities, including third party administrators (TPAs)and pharmacy benefit managers(PBMs), that have claims and other required data	BISHCA	06/01/07
Issue an RFP for the development and management of the health insurance claims data collection, data base, and reporting system	BISHCA	06/01/07
Select a vendor for development and management of the health insurance claims data collection, database, and reporting system.	BISHCA	09/01/07
Establish rules for the collection, management and reporting of health insurance claims data including required participation and enforcement, data submission standards, security, privacy protections, and policy and procedures addressing permissible data release and reporting.	BISHCA	09/01/07
Collect an initial test set of claims data from required participants	BISHCA	01/31/08
Report out on compliance, technical barriers, data quality, and responsiveness of required participant to corrective action plans in preparation for full implementation of data collections	BISHCA	04/01/08
Implement full data collection, processing, data base development and reporting capabilities	BISHCA	06/01/08
VITL and VPQHC access to the BISHCA healthcare database subject to such terms and conditions as the commissioner may prescribe by regulation.	BISHCA	01/31/09

Proposed Statutory Changes:

- CMS requires that Medicaid data only be shared for purposes of administering the Medicaid program. In order to comply with this federal requirement, both Maine and New Hampshire only share with non-state government entities aggregate, de-identified data in their multi-payer database. As such, Vermont needs to explore whether the permissive language in 18 V.S.A. §9417(b)(8) that provides VITL and VPQHC access to multi-payer database data is too broad to comply with federal requirements. If so, this language will need to be changed.

- Amend 18 V.S.A. §9410 to permit BISHCA to charge a fee for access to the data contained in the health care database.

8.3. *Adverse Event Reporting.*

The Vermont Department of Health is required to develop a Patient Safety Surveillance and Improvement System to improve patient safety, eliminate adverse events, and support quality improvement efforts. Hospitals must develop internal polices to track medical events and analyze the causes, with protections for patient confidentiality and peer review, and they must report to patients or family when an adverse event causes death or serious bodily injury. Hospitals must provide information to the Health Department relating to certain reportable adverse events. Information on hospital medical events and hospital infection rates will be reported to the public on an annual basis through hospital community reports

2011 Strategic Goal: *Vermont Hospitals and the Department of Health work as partners on a comprehensive statewide patient safety surveillance and improvement system that is continuously improving patient safety, reducing adverse events in Vermont Hospitals and supporting and facilitating quality improvement by hospitals.*

Milestone(s):

Establish system to collect and analyze data, verify hospital compliance, provide technical assistance	Dept. of Health	06/30/07
Adverse event rulemaking for hospital organizations	Dept. of Health	06/30/07
Interim report on status and effectiveness of adverse event system	Dept. of Health	01/15/08
Final report and recommendations on expansion of adverse event system	Dept. of Health	01/15/09
Recommend to BISHCA which adverse event data to include in Hospital Community Reports (18 months after data available)	Dept. of Health BISHCA	03/01/09
Adverse event reporting system is fully functional and used routinely by all hospitals.	Dept. of Health	12/31/11

Proposed Statutory Changes:

None.

8.4. *Safe Staffing.*

Hospital nurse staffing measures must be made available to patients and the public in Hospital Community Reports and through daily public posting in hospitals.

2011 Strategic Goal: *All Vermont consumers will have access to information on nurse staffing in hospitals through annual reporting in Hospital Community Reports and through daily public posting in hospital units.*

Milestone(s):

Begin daily posting of nurse staffing in hospital units	Hospitals	07/01/06 Completed
Research nurse staffing measures that are appropriate for public reporting in Hospital Community Reports	BISHCA	11/15/06 Completed
Determine reporting mechanisms for selected measure(s)	BISHCA	12/15/06
Prescribe data collection time period.	BISHCA	12/15/06
Add nurse staffing measures to Hospital Community Reports	BISHCA	06/01/08

Proposed Statutory Changes:
None.

8.5. *SorryWorks!.*

Another component of the health care reform legislation is a voluntary, pilot SorryWorks! program in which physicians and hospitals promptly acknowledge and apologize for mistakes in patient care that result in harm and promptly offer fair settlements. Such an oral apology or explanation of how the medical error occurred, made within 30 days, may not be used to prove liability, is not admissible, and cannot serve as the subject of questioning in administrative or civil proceedings. Negotiations under SorryWorks! are confidential, and the statute of limitations is tolled during negotiations. A settlement resulting from participation in the SorryWorks! program bars further litigation; if settlement is not reached, the patient may bring a civil action.

2011 Strategic Goal: *Vermont has a medical malpractice system which improves patient safety, enhances the doctor patient relationship and lowers the overall costs of medical malpractice for providers and patients.*

Milestone(s):

Continue to work with hospitals and their insurance agents to assess needed statutory changes to facilitate their participation in the program	BISHCA VAHHS	01/01/07
Submit propose statutory changes to legislature	BISHCA	01/01/07
Work with hospitals and insurers to participate and initiate rulemaking to implement program if parties are participating	BISHCA	04/01/07
Engage one or more hospitals and their insurance agents to begin pilot program	BISHCA	07/01/07
Pilot implementation & recommendation report to Legislature	BISHCA	01/15/09
Pilot program sunsets	BISHCA	06/01/09

⚑ If pilot program is successful, work with other hospital and their insurance agents to implement SorryWorks!	BISHCA	06/01/09 and Beyond

Proposed Statutory Changes:

- Amendments to the Sorry Works! program may be necessary to facilitate participation in the program. Specifics will not be known until the interested parties fully explore their options. A proposal to the Legislature is expected in January 2007.

8.6. *Advance Directives.*

The health care reform legislation enhances Vermont's Advanced Directives statutes by requiring health care providers to notify the registry and submit a copy of any amendments, suspensions, and revocations about which it knows. It also clarifies that an advance directive can specify who can and cannot bring probate court action and the probate court must honor this. The law is also applied to "procurement organizations" as appropriate.

2011 Strategic Goal: *Vermonters will prepare advance directives and file them in the Registry, and providers will be able to retrieve them from the Registry quickly and easily to ensure that patients' health care and end of life wishes are honored.*

Milestone(s):

⚑ Initiate rule-making process for Advanced Directive Forms	Dept. of Health	08/30/06 Completed
⚑ As existing licenses & ID cards are depleted, issue new cards allowing Advanced Directive indication	DMV	09/01/06 Completed
⚑ Adopt rules for Advanced Directive registry	Dept. of Health	12/13/06
⚑ Establish Advanced Directive registry	Dept. of Health	12/13/06
⚑ Provide Advanced Directive information on the web-site	Dept. of Health	12/15/06
⚑ Provide stickers for people in registry	Dept. of Health	01/01/07

Proposed Statutory Changes:

- Current statutory authority does not enable the Health Department to make rules or forms which recognize surrogate authority in situations other than those specifically authorized by the Vermont Legislature (i.e., it does not permit surrogates to authorize limitations of treatment other than Do Not Resuscitate). Many on the Advanced Directives work group believe this authority should be expanded to allow the Clinician Order for Life Sustaining Treatment (COLST) form to include surrogate authority for other life-threatening situations.

- Similarly, the definition of "experimental treatment" and how it may be dealt with in advance directives is vague, and may require legislative clarification.

8.7. *Infection Reporting in Hospital Community Reports.*

Hospitals are required to report valid, reliable and useful measures of hospital-acquired infections in their annual Hospital Community Reports.

2011 Strategic Goal: *Vermont consumers and others will have access to accurate, reliable and understandable information on hospital-acquired infections, resulting in informed consumers and reductions in infections.*

Milestone(s):

Convene Infection Reporting Advisory Subcommittee of Act 53 Hospital Community Reports Work Group	BISHCA	09/30/05 Completed
Identify potential infection measures for public reporting.	BISHCA	01/12/06 Completed
Determine reporting mechanisms (CDC's National Healthcare Safety Network) for selected measures and coordinating body (VPQHC) for inquiries and data analysis	BISHCA /VPQHC	08/20/06 Completed
Establish training schedule for hospitals to and enroll in CDC system	BISHCA /VPQHC	11/10/06 Completed
Collect data for 2007 public reporting of central line infection rates	Affected Hospitals	11/01/06 - 04/30/07
Publish data in 2007 Hospital Community Reports	BISHCA /VPQHC /Hospitals	06/01/07
Repeat process for additional measures	BISHCA /VPQHC /Hospitals	06/01/07 and Beyond

Proposed Statutory Changes:

None.

REFORM GOAL: CONTAIN HEALTH CARE COSTS

Increasing Access to Insurance and Improving Quality of Care

All of the initiatives described above that increase insurance coverage and improve quality of care are expected to have a direct effect on containing Vermont's health care costs. For example, reducing the number of uninsured and underinsured people, increasing the rates paid by public health insurance programs, and assisting enrollment in employer-sponsored insurance programs will reduce the cost shift, which in turn will reduce increases in health care premiums. In addition, the Blueprint and the multiple other efforts related to prevention and chronic care are built on the premise that preventing disease and improving the quality of care for people with chronic illness are effective ways to reduce the overall demand for high-cost treatment

services and reduce health care costs throughout the system. Improved quality of care and cost savings also are anticipated from implementation of many other initiatives, including the provision of transparent price and quality information, the adverse events system, and SorryWorks! In addition, there are specific initiatives described below that are aimed at directly decreasing the cost shift and improving administrative efficiencies to control escalating costs.

9. Decrease Cost Shift

9.1. *Medicaid Provider Reimbursement Increases.*

Significant Medicaid provider underpayments can threaten access to care, and underpayments result in a cost shift to commercial plans that must be paid by commercial health insurance premiums. To begin to address this, the Health Care Reform legislation increases Medicaid provider reimbursements in the following manner: (I) evaluation and management services will be paid at Medicare rates in order to support primary care physician practices; (ii) supplemental payments will be provided to dentists with high Medicaid patient counts; and (iii) hospital rates will be increased annually until the federal upper limit is reached.

2011 Strategic Goal: *The cost shift resulting from insufficient Medicaid reimbursement rates will be reduced.*

Milestone(s):

Submit preliminary findings re: impact of federal Deficit Reduction Act generic drug provision on pharmacists and patients	OVHA	09/01/06 Completed
Provide supplemental payments to dentists with high Medicaid patient counts; Provide report to HAOC on program parameters	OVHA	10/01/06 Completed
Report to HAOC plan for allocation of FY '07 appropriations for provider and hospital rate changes	OVHA	10/31/06 Completed
Part D cost projections report to HAOC	OVHA	12/01/06
Submit final report on impact of Federal Deficit Reduction Act generic drug provision on pharmacists and patients	OVHA	01/30/07
Increase dental rates: First restore 02/06 cuts, then split remainder in half to increase dental rates and adult dental cap	OVHA	01/01/07
Increase base rates for current CPT codes that are significantly below 2006 Medicare, starting with lowest codes	OVHA	01/01/07
Increase OVHA base rates for evaluation management and procedure codes to 2006 Medicare rates	OVHA	01/01/07
Increase hospital rates annually until federal upper limit is reached, within available resources	OVHA	01/01/07 and Beyond

⚑ Continue to increase Medicaid provider rates, within available resources	OVHA	07/01/08 and Beyond

Proposed Statutory Changes:
None.

9.2. *Other Cost Shift Initiatives.*

Individuals and businesses who pay commercial health insurance premiums pay additional premium because of the shifting of costs attributable to the uncompensated care of the uninsured, and attributable to Medicaid and Medicare underpayments. The Department of Banking, Insurance, Securities and Health Care Administration will undertake several cost shift initiatives, including:

- Requiring hospitals to account for Medicaid reimbursement increases in their annual budgets established by the department.
- Standardizing hospital bad debt and free care policies.
- Developing procedures to account for changes in uncompensated care and Medicaid reimbursement when the department approves health insurance rates.

2011 Strategic Goal: *Enhanced provider and payer reporting systems will be in place to enable the State to monitor and evaluate changes in the cost shift and to measure the effect of cost shift changes on hospital and commercial insurance rates.*

Milestone(s):

⚑ Convene Task Force to make recommendations re: statutory/admin changes to reduce cost shift (via slower growth rate in hospital charges & insurance premiums)	BISHCA	10/30/06 Completed
⚑ Task Force report on recommendations re: statutory/admin changes to reduce cost shift	BISHCA	12/01/06
⚑ Recommend standard statewide uniform policy for hospital uncompensated care and bad debt	BISHCA	01/15/07
⚑ Change hospital reporting requirement to reflect any increase in federal reimbursements, increase in # insured, decrease in bad debt/charity	BISHCA	04/30/07
⚑ Report on cost shift	BISHCA	Annually

Proposed Statutory Changes:
None.

10. Simplify Health Care Administration

10.1. *Common Claims and Procedures*.

The Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) is charged with adopting regulations designed to simplify the claims administration process, and to lower administrative costs in the health care financing system.

2011 Strategic Goal: *Vermont insurers and providers will implement coordinated, improved and simplified claims administration and other procedures to lower administrative costs and provide more understandable and less time-consuming processes for consumers, health care providers, insurers and others.*

Milestone(s):

Establish common claims and procedures work group	VAHHS /BISHCA	07/01/06 Completed
Present two-year work plan and budget to House Committee on Health Care and the Senate Committee on Health and Welfare	VAHHS /BISHCA	09/01/06 Completed
Present interim report on progress and interim steps	VAHHS /BISHCA	01/15/07
Final report with findings and cost savings achieved and expected future savings	VAHHS /BISHCA	01/15/08
Amend rules adopted pursuant to 18 VSA §9408 to reflect recommendations in common claims report	BISHCA	07/01/08
Oversee implementation of new administrative procedures.	BISHCA	07/01/08 and Beyond

Proposed Statutory Changes:
None.

10.2. *Uniform Provider Credentialing.*

BISHCA is also charged with prescribing a standard credentialing application form to be used by insurers and hospitals for credentialing their providers. Insurers and hospitals are required to inform providers of deficiencies in their applications, according to statutory timeframes.

2011 Strategic Goal: *All insurers and hospitals will use the Council for Affordable Quality Healthcare (CAQH) credentialing application form, resulting in reduced administrative costs and increased time savings for providers, insurers and hospitals.*

Milestone(s):

Convene meeting to obtain input from insurers, hospitals providers and CAQH.	BISHCA	09/21/06 Completed

Develop and distribute draft bulletin to interested parties	BISHCA	11/05/06 Completed
Receive comments from interested parties.	BISHCA	11/17/06 Completed
Draft and distribute final bulletin	BISHCA	12/01/06
Provide training opportunities and educational resources for insurers, hospitals and providers	BISHCA/CAQH	12/15/06
Ensure that new uniform credentialing application form is used by insurers and hospitals	BISHCA/Insurers /Hospitals	01/01/07 and Beyond

Proposed Statutory Changes:
None.

FINANCING VERMONT'S HEALTH CARE REFORM

2011 Strategic Goal: *There are viable financing mechanisms in place to sustain Vermont's health care reform initiatives.*

11. Catamount Health Fund

This new fund is established in Fiscal Year 2007 as a source of funding for the Catamount Health and ESI premium assistance programs, the Immunization Initiative, the Non-Group Market Security Trust, and other transfers approved by the General Assembly. Sources of revenue include 17.5 % of the new cigarette taxes (see12 below), the Employers' Health Care Premium Contribution (see 13 below), Catamount Health premium assistance amounts paid by individuals to the State (see 2.1), and other revues established by the General Assembly.

Milestone(s):

Establish and report to JFC on receipts, expenditures and balances of the Catamount Fund	DF&M	09/15/07 and Annually at Sept. Meeting

Proposed Statutory Changes:
None.

12. Increases in Tobacco Product Taxes

Milestone(s):

Increase cigarette tax by $.60 per pack	Dept. of Taxes	07/01/06 Completed
Institute a new tax on "little cigars" and roll-your-own tobacco as cigarettes	Dept. of Taxes	07/01/06 Completed
Increase cigarette tax by $.20 per pack increase	Dept. of Taxes	07/01/08
Change the method of taxing moist snuff to a per-ounce basis and increases tax by $.17	Dept. of Taxes	07/01/08

Proposed Statutory Changes:
None.

13. Employers' Health Care Premium Contribution

Employers will pay an assessment based on their number of "uncovered" employees, based on the following guidelines:

- Employers without a plan that pays some part of the cost of heath insurance of its workers must pay the health care assessment on all their employees.
- Employers who offer health insurance coverage must pay the assessment on workers who are ineligible to participate in the health care plan, and on workers who refuse the employer's health care coverage and do not have coverage from some other source.

The assessment is based on full-time equivalents at the rate of $91.25 per quarter ($365 per year), exempting eight FTEs in fiscal years 2007 and 2008, six FTEs in 2009, and four FTEs in and after 2010. The assessment rate will increase annually, indexed to the Catamount Health Plan premium growth.

Milestone(s):

Establish rules for employer assessment (administration and premium collection)	Dept. of Labor	01/01/07
Report to General Assembly on options to include seasonal employees in employer assessment	Dept. of Labor	01/15/07
Implement employer assessment (first payment due July 30, 2007)	Dept. of Labor	04/01/07
Change employer contribution amount based on Catamount health plans premium increases.	Dept. of Labor	04/01/08 and Annually

Proposed Statutory Changes:

- The current statute applies a penalty for non-payment but does not give VDOL tools to collect delinquent contributions. Giving VDOL the same authority to pursue collections of the health care assessment that is found in 21 V.S.A. §1334 & 1336 will allow for a more efficient collection system and reasonable enforcement.

14. Medicaid Global Commitment to Health Program

In 2005 Vermont entered into a new five year comprehensive 1115 federal Medicaid demonstration waiver named Global Commitment to Health (GC). This waiver is designed to: 1) provide the state with financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services; 2) continue to lead the nation in exploring new ways to reduce the number of uninsured citizens; and 3) foster innovation in health care by focusing on health care outcomes. The Waiver program consolidates funding for all of the state's Medicaid programs, except for the new Choices for Care (long-term care) waiver and several small programs (SCHIP and DSH payments for hospitals). It also converts the Office of Vermont Health Access (OVHA), the state's Medicaid organization, to a public Managed Care Organization (MCO). Under this new waiver, the MCO can invest in health services that typically would not be covered in our Medicaid program, and Vermont's Medicaid program has programmatic flexibility to implement creative programs and reimbursement mechanisms to help curb our health care costs. The State has requested an amendment from CMS to include Catamount Health and the employer-sponsored insurance premium assistance programs under the financial umbrella of this waiver.

Milestone(s):

Submit GC waiver amendment request to CMS to establish (& include in MCO premium rate) the ESI and Catamount premium assistance program for VHAP & uninsured up to 300% FPL; if not approved, may use MCO investment process	AHS/OVHA	09/11/06 Request Submitted
Health Access Oversight Committee (HAOC) Report regarding recommendations to eliminate Medicaid deficit	HAOC	01/15/07

Proposed Statutory Changes:
None.

15. Medicaid VHAP program savings due to employer-sponsored insurance enrollment

Milestone(s):

Report on number enrolled, income levels, description of approved ESI plans, employer cost related to premium assistance program, and net savings of program. [19]	DCF/OVHA	Monthly after 10/01/07

Proposed Statutory Changes:
None.

[19] *Report must be submitted to the Health Access Oversight Committee, the Joint Fiscal Committee, and the Health Care Reform Commission.*

16. State General Fund Appropriations

Milestone(s):

Ensure that annual appropriations enable successful implementation of the health care reform initiatives.	Governor General Assembly	Annually

Proposed Statutory Changes:
None.

17. State Fiscal Obligations Protected

The health care reform legislation enables the state Emergency Board (E-Board) to establish caps on enrollment in the Premium Assistance Programs if sufficient funds are not available to sustain them.

Milestone(s):

Provide to E-Board revenue estimates of Global Commitment, state health care resources & Catamount funds for current and 2 future FYs, & estimated monthly caseloads & PMPM for GC, LTC, VT Rx, Catamount Health & premium assistance programs	AoA/DF&M /AHS	Annually (January E-Board meeting)
Provide to E-Board revenue estimates of Global Commitment, state health care resources & Catamount funds for current and immediately succeeding FYs, & estimated monthly caseloads & PMPM for GC, LTC, VT Rx, Catamount Health & premium assistance programs	AoA/DF&M /AHS	Annually (July E-Board meeting)
Emergency Board review of cost compared to available resources; potential decision to suspend new enrollment	E-Board	Semi-annually (Jan. & July)

Proposed Statutory Changes:

- An inconsistency was created between Act 191 §46 and Act 215 §315 of the 2006 Session regarding the purview of the Emergency Board for their official state revenue estimates. The former includes financials regarding Catamount Health, while the latter does not. In addition, the reference to Medicaid enrollment group determination is conflicting. As such, §315 of Act 215 of the 2006 Session should be repealed.

HEALTH CARE REFORM OVERSIGHT

2011 Strategic Goal: *Vermont will have achieved the goals of the 2006 Health Care Reform legislation and other initiatives enacted into law in subsequent years..*

Milestone(s):

Create commission on Health Care Reform to ensure system of care and universal access by 2009; provides for consultation for IT & other implementation	General Assembly	07/01/06 Completed
Submission of five-year implementation plan for reforms, including recommendations for administration/legislation	AoA	12/01/06 Completed
Develop web-site for health care reform implementation	AoA	12/31/06
Report on progress of reform initiatives	AoA	01/15/07 and Monthly
Work collaboratively with the legislature to identify new initiatives to help achieve health care reform goals.	Governor and Administration	On-going
Determine needed analysis and criteria for changing health care financing and delivery system if less than 96% of Vermonters have insurance by 2010	HCR Commission	01/01/11

Proposed Statutory Changes:

None.

SUMMARY OF PROPOSED STATUTORY CHANGES

REFORM GOAL: INCREASE ACCESS TO AFFORDABLE HEALTH INSURANCE

1. Enhance Private Insurance Capacity

1.1. <u>Catamount Health Plan.</u>

Proposed Statutory Changes:

- The current language in 8 V.S.A. §4080f(m)(1) states that "A carrier shall notify the department that it intends to offer Catamount Health by filing written notice of that intent no later than 30 days after the effective date of the expedited adoption of Catamount Health rules." This technically prohibits a new carrier from being able to offer Catamount health in future years. The language must be revised to allow future carriers to offer the Catamount Health Plan.

- Current eligibility for Catamount Health Plans allows an individual to qualify without being uninsured fro 12 months due to loss of loss of employment. It is unclear whether the General Assembly fully contemplated the effect of this on the Catamount Health Plan, the Catamount Health Premium Assistance program, or employer-based insurance if it allows individuals who retire to immediately enroll in Catamount Health Plans. The Administration proposes language to clarify this intent.

- Statutory clarification is needed to ensure that BISHCA is authorized to permit insurers to deny Catamount Health coverage to employees whose employer drops coverage solely for the purpose of enabling employees to enroll in Catamount Health Plans.

- Statutory clarification is needed regarding the standard for provider reimbursement under Catamount Health (Medicare +10% or +2%).

- Statutory clarification is needed regarding legislative intent to prohibit balance billing.

1.2. <u>Non-group Market Consolidation Study.</u>

Proposed Statutory Changes:

- The need for statutory changes will not be known until January 2007, after completion of the study.

2. Provide Assistance with Insurance Affordability

2.1. <u>Catamount Health Premium Assistance Program.</u>

Proposed Statutory Changes:

- 33 V.S.A. §1985(b) states "an individual applying for or enrolled in the program established under this subchapter who is aggrieved by an adverse decision of the agency may grieve or appeal the decision under rules and procedures consistent with 42 CFR §438.402." The citation is to the global commitment grievance process, but this process is only for coverage grievances, not eligibility grievances. The statute needs to be changed to refer to the fair hearing process that AHS uses for eligibility disputes.

- The Statute has a discrepancy regarding income levels related to premium assistance. 33 V.S.A. §1974(c)(2)(B) states that coverage is available to individuals with incomes under 300% of FPL, but the language in 33 V.S.A. §1984(c)(5) regarding monthly premiums specifies a premium of $135 for individuals with incomes greater than 275 percent and less than or equal to 300%." The language needs to be changed to consistently reference "under 300%."

- The Administration believes that Act 191 intended to create an integrated system of state assistance programs to better assure the continuity of health care to covered beneficiaries. To this end, we believe that the legislative intent was that individuals who fall out of one assistance category may transition into another when eligibility requirements are met. (See Appendix B for a graphic of possible transitions). However, not all of these possible transitions are sanctioned in statute.20 We propose the following three statutory additions to assure clear authority for each of the identified transitions:

  Insert as new paragraph (d) in 33 V.S.A. § 1974: If, after enrollment in a premium-assistance program described in paragraph (a) or (b) of this section, the individual's eligibility for the Vermont health access plan should change, the individual's premium-assistance program enrollment shall be modified accordingly.

  Insert as new paragraph (e) in 33 V.S.A. § 1974: Individuals who have Catamount Health or who are enrolled in the Catamount Health Assistance Program may be enrolled in an employer-sponsored premium assistance program without being uninsured for 12 months.

  Insert as new subparagraph (a) (4) in 33 V.S.A. § 1983: Individuals who have Catamount Health may be enrolled in the Catamount Health Assistance Program without being uninsured for 12 months.

- The premium payment amounts for Catamount Health are defined in statute at a fixed amount with no inflationary increases over time. The Administration believes that these rates should be adjusted annually based on a nationally-recognized cost of living index.

2.2. <u>Employer Sponsored Insurance (ESI) Premium Assistance Program.</u>
Proposed Statutory Changes:

- To assist with smooth transition, eligibility for VHAP should be a "qualifying event" that allows an individual to enroll in their employer-sponsored insurance (ESI) outside of the employer's open enrollment period. Therefore, we propose adding language that provides BISHCA with the statutory authority to adopt rules requiring carriers to allow this provision.

2.3. <u>Decrease VHAP Premiums and Medicaid Eligibility Reviews</u>
Proposed Statutory Changes:

- The Administration believes that the premium amounts for VHAP should be adjusted annually based on a nationally-recognized cost of living index.

- Others changes to premium amounts to be determined annually by Governor's proposed budget and the General Assembly's appropriation to ensure financial stability of the Medicaid, VHAP and Dr. Dynasaur programs.

[20] I*nitial transitions from Medicaid and VHAP into Catamount Health or ESI and transitions from one of the new programs back into Medicaid are all expressly contemplated in the law.*

REFORM GOAL: IMPROVE QUALITY OF CARE ACROSS THE LIFESPAN

4. Improve Chronic Care Management

4.1. <u>Blueprint for Health – the State's Chronic Care Plan.</u>

Proposed Statutory Changes:

- 18 V.S.A. §702(b) (1) establishes the Blueprint Executive Committee and its membership. In doing so, it designates that the Executive committee shall have a representative from the Vermont Program for Quality in Health Care (VPQHC), which is also a potential (and current) grantee of the Blueprint. To eliminate an explicit conflict of interest required by statute, the State recommends that this statutory reference be changed to a representative from "a statewide quality assurance organization."

4.2. <u>OVHA Chronic Care Management Program (CCMP).</u>

Proposed Statutory Changes:

- 33 V.S.A. §1903a (7) requires the care management vendor's fee to be at risk for guaranteed savings. This full risk concept for an independent vendor is at odds with the goal of the Blueprint, where the patient and the provider are seen as key to successful goal attainment. In addition, research indicates that "guaranteed savings" contracts may not be advantageous for the State. As such, the State proposes to amend this section to permit only portions of the contract to be at financial risk.

4.3. <u>Medicaid Reimbursement Incentives for Participating in CCMP.</u>

Proposed Statutory Changes:

- Propose amendment to statutory timeframe to align with OVHA's Chronic Care Management Program and the statewide implementation of Blueprint.

4.5. <u>Employer-Sponsored Insurance (ESI) Premium Assistance Chronic Care Coverage.</u>

Proposed Statutory Changes:

- The standard for approving and wrapping VHAP ESI plans for chronic care in section 13 of Act 191 is inconsistent with other sections related to chronic care in Act 191(Sections 5, 6, 7, and 15). The standard should be consistent across all the programs. 33 V.S.A. §1974(c) (3) should be amended to read: "Until an approved employer-sponsored plan is required to meet the standard in subdivision (4) (B) (ii) of this subsection, the subsidy shall include premium assistance and assistance to cover all cost-sharing amounts for ~~chronic care~~ <u>participation in chronic care management, consistent with the criteria and requirements of chapter 13 of Title 18 and section 1903a of Title 33.</u>"

- Consistent with legislative intent that the Blueprint guide the state's chronic care management implementation, the Administration believes that the standards to be used for approving Chronic Care Management Programs within ESI plans should be determined by Blueprint Executive Committee.

5. Increase Provider Access to Patient Medical Information

5.1. <u>Health Information Technology.</u>

Proposed Statutory Changes:

- Statutory changes may be needed to facilitate physician provision of information into the chronic care information system.

5.3. Loan Program for Physician Electronic Medical Records Infrastructure.

Proposed Statutory Changes:

- Act 215 created the mandate for BISHCA to develop this program in consultation with other state departments and agencies and VITL, but did not include an appropriation. The Administration believes that this program would be more properly aligned with the Blueprint implementation and proposes that the Department of Health be given the statutory authority to implement this program as resources are made available.

6. Promote Wellness

6.1. Free Immunizations.

Proposed Statutory Changes:

- As it is currently written, the following sentence in 18 V.S.A. §1130(b) would violate the federal requirement that Medicaid be the payer of last resort:: The department shall be the secondary payer to Medicaid, the Vermont health access plan, Dr. Dynasaur, Medicare, and any federal health insurance or federal program covering immunizations. We propose the following language to meet federal requirements and to ensure that we maximize federal participation: The department shall be the payer only for those residents not enrolled in Medicaid, the Vermont health access plan, Dr. Dynasaur, Medicare, or any federal health insurance or federal program covering immunizations.

8. Promote Quality Improvement

8.2. Multi-payer Data Collection Project.

Proposed Statutory Changes:

- CMS requires that Medicaid data only be shared for purposes of administering the Medicaid program. In order to comply with this federal requirement, both Maine and New Hampshire only share with non-state government entities aggregate, de-identified data in their multi-payer database. As such, Vermont needs to explore whether the permissive language in 18 V.S.A. §9417(b)(8) that provides VITL and VPQHC access to multi-payer database data is too broad to comply with federal requirements. If so, this language will need to be changed.

- Amend 18 V.S.A. §9410 to permit BISHCA to charge a fee for access to the data contained in the health care database.

8.5. SorryWorks!.

Proposed Statutory Changes:

- Amendments to the Sorry Works! program may be necessary to facilitate participation in the program. Specifics will not be known until the interested parties fully explore their options. A proposal to the Legislature is expected in January 2007.

8.6. Advance Directives.

Proposed Statutory Changes:

- Current statutory authority does not enable the Health Department to make rules or forms which recognize surrogate authority in situations other than those specifically authorized by the Vermont Legislature (i.e., it does not permit surrogates to authorize limitations of treatment other than Do Not Resuscitate). Many on the Advanced Directives work group believe this authority should be expanded to allow the Clinician Order for Life Sustaining Treatment (COLST) form to include surrogate authority for other life-threatening situations.

- Similarly, the definition of "experimental treatment" and how it may be dealt with in advance directives is vague, and may require legislative clarification.

REFORM GOAL: CONTAIN HEALTH CARE COSTS

13. Employers' Health Care Premium Contribution

Proposed Statutory Changes:

- The current statute applies a penalty for non-payment but does not give VDOL tools to collect delinquent contributions. Giving VDOL the same authority to pursue collections of the health care assessment that is found in 21 V.S.A. §1334 & 1336 will allow for a more efficient collection system and reasonable enforcement.

17. State Fiscal Obligations Protected

Proposed Statutory Changes:

- An inconsistency was created between Act 191 §46 and Act 215 §315 of the 2006 Session regarding the purview of the Emergency Board for their official state revenue estimates. The former includes financials regarding Catamount Health, while the latter does not. In addition, the reference to Medicaid enrollment group determination is conflicting. As such, §315 of Act 215 of the 2006 Session should be repealed.

APPENDIX A--GLOSSARY OF ACRONYMS AND TERMS

Term	Description/Definition
Administration	The Administrative arm of state government; used in this document to refer to situations when multiple agencies and departments across state government are involved
AHEC	Area Health Education Centers
AHS	Vermont Agency of Human Services
AoA	Vermont Agency of Administration
BISHCA	Vermont Department of Banking, Insurance, Securities and Health Care Administration
Blueprint for Health	The state's plan for chronic care infrastructure, prevention of chronic conditions, and Chronic Care Management Program, and includes an integrated approach to patient self management, community development, health care system and professional practice change, and information technology initiatives.
Care coordination	A component of Chronic Care Management that includes intensive intervention and support for people with advanced disease, multiple complications. May also be referred to as case management
CCIS	Chronic Care Information System: The electronic database developed under the Blueprint for Health that shall include information on all cases of a particular disease or health condition in a defined population of individuals.
Chronic Care	Health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions.
Chronic Care Management	A system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for the physician and patient relationship, and a plan of care emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.
Chronic Care Model	A national model for collaborative care and quality improvement that illustrates the components necessary to improve care for people with chronic conditions within a health care setting.
Chronic condition	Chronic illnesses and impairments that are expected to last a year or more, limit what the individual is able to do, and/or require ongoing medical care.
CMS	Centers for Medicare and Medicaid Services
DCF	Vermont Department for Children and Families
DHR	Vermont Department of Human Resources
DII	Vermont Department of Information and Innovation
DMV	Vermont Department for Motor Vehicles

Term	Description/Definition
E-Board	The Board is established in Vermont Statute to have the authority to make any expenditure necessitated by unforeseen emergencies and may borrow on the credit of the state for the same. Members of the Emergency Board are the Governor, the chairman of the Senate finance committee, the chairman of the Senate appropriation committee, the chairman of the House ways and means committee and the chairman of the House appropriation committee.
F&M	Vermont Department of Finance and Management
HAOC	Health Access Oversight Committee of the Vermont Legislature
Healthcare Providers	The physicians, nurse practitioners, physician assistants, nurses, counselors, and other health and public health professionals who work with individuals to guide, support and assist them to be healthy, and who deliver treatment and care when needed.
HCR	Health Care Reform
JFC	Joint Fiscal Committee of the Vermont Legislature
OVHA	Office of Vermont Health Access (Medicaid)
VHAP	Vermont Health Access Plan (public health insurance program for uninsured adults who are not eligible for Medicaid).
VDH	Vermont Department of Health
VDOL	Vermont Department of Labor
VITL	Vermont Information Technology Leaders
VPQHC	Vermont Program for Quality in Health Care